Billing Manual for Swing Bed Facilities

Medical Services
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INTRODUCTION

The purpose of this manual is to outline billing procedures for services provided to individuals eligible for Medical Assistance by swing bed facilities.

BASIC BILLING GUIDELINES FOR SUBMITTING SWING BED CLAIMS

- Swing Bed claims must be submitted to North Dakota Medicaid on paper (UB-92 form) or electronically using the ANSI X12 4010A1 837 Institutional Health Care Claim transaction.

- Swing Bed claims must be submitted to North Dakota Medicaid using a *Bill Type* **181-184.** Use of any other Bill Type other than **181-184** for Swing Bed claims will be invalid.

- Swing Bed claims must be submitted to North Dakota Medicaid using the following *Revenue Codes* when billing for:

Revenue Code **110 - 159**	In-House Medicaid days
Revenue Code **169**	Medicare Coinsurance

  Use of any other Revenue Codes for Swing bed claims will be invalid and will be returned for correction.

- The rate established for swing bed facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing supplies, equipment, transportation, and non-legend drugs. Separate billings for these items will not be paid. Enter only the Room and Board charges on the UB-92 form or electronic billing format. DO NOT ENTER ANCILLARY CHARGES. Ancillary charges that are not included in the swing bed rate, such as x-ray, lab, etc. must be billed using your hospital's provider number as an outpatient claim (**bill type 13x**). Pharmacy charges must be billed on a pharmacy claim form.

- Facilities must submit a claim for every month a Medicaid resident is in your facility, even if insurance (including Medicare) has paid for the charges. You must submit a claim with a zero billing even if there is no balance left for Medicaid to reimburse. This is important because when we receive the long-term care claim (even if zero billing), it allows the system to start applying other claims we receive towards recipient liability. The claim should be submitted immediately after the month is over. Enter the entire amount in Form Locator #54 (PRIOR PAYMENTS) and zero (0) amount in Form Locator #55 (ESTIMATED AMOUNT DUE).

- Only bill for Medicare coinsurance days and Medicare coinsurance amounts using **Revenue Code 169**. You do not have to wait until you receive the actual payment or explanation of benefits from Medicare, just enter an estimate of the insurance payment in the other insurance field on your claim form. If the actual insurance payment received is different than the estimate used, complete an adjustment claim to correct the difference. If a claim has been denied, please correct and resubmit immediately.

- Leave Days -- Payment is not available for any period that an individual does not actually occupy a bed. If an individual leaves the facility without being discharged, for example, the individual visits relatives on a weekend; the days the individual is out of the facility will not be paid. Leave day status is determined at midnight.

- Medicaid cannot make payment for swing bed services to the swing bed provider for an individual who is receiving hospice care. The hospice is paid the swing bed rate and the hospice is responsible for payment of the swing bed services provided to a Medicaid recipient. Once a recipient has elected hospice benefits, the swing bed provider may not submit a claim for services provided while the recipient is on hospice.

- Submit Swing Bed charges monthly but DO NOT bill more than one calendar month per claim

INSTRUCTIONS FOR COMPLETING SWINGBED CLAIMS

Listed below are instructions addressing all required fields for submission of swing bed claims to North Dakota Medicaid. The **form locators (FL)** for the paper UB-92 claim form are listed below along with an explanation of the field. These fields will also be required if the claim is being submitted electronically. Please see the ANSI X12 4010A1 837 Institutional companion guide for any Medicaid specific data field requirements. For electronic transactions, you must report the required fields that correspond to the appropriate data segment/field in the electronic claim format.

FL1 (PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER):

- Enter the provider name, address and telephone number.

FL3 (PATIENT CONTROL NUMBER):

- (Optional) Enter the patient control number. The number will appear on the remittance advice (RA).

FL4 (TYPE OF BILL):

- Enter the 3-digit type of bill identifying type of facility, bill classification, and frequency. North Dakota Medicaid will require use of **Bill Type 181-184** for swing bed claims. Use of any other Bill Type for swing bed claims will be invalid.

FL6 (STATEMENT COVERS PERIOD):

- Enter the first date of service and the last date of service for the monthly billing period on this claim. The dates must be continuous. Enter the "From" and "Through" dates of service in MMDDYY format. If the claim covers only one day of service, the "From" and "Through" dates must be equal. The "statement covers period" includes the first date of service through the last date of service, which would **include** the actual discharge date, the hospice election date, or date of death, whichever is applicable. ND Medicaid will automatically calculate and disallow any non-covered days by using the Revenue Code field and Discharge Code field.

FL7 (COVERED DAYS):

- Enter the number of covered days, which would include the actual discharge date, the hospice election date, or date of death, whichever is applicable. The number should equal the statement covers period (FL 6). ND Medicaid will automatically calculate and disallow any non-covered days by using the Revenue Code field and Discharge Code field.

FL8 (NON-COVERED DAYS):

- **DO NOT** use this field. ND Medicaid will automatically calculate non-covered days using the Revenue Code field and Discharge Code field.

FL12 (PATIENT NAME):

- Enter the recipient's last name, first name, and middle initial.

FL14 (PATIENT BIRTHDATE):

- Enter the recipient's birth date in MMDDYYYY format.

FL17 (ADMISSION DATE):

- Enter the date of admission in MMDDYY format

FL18 (ADMISSION HOUR):

- Enter the hour of admission (00-23). If unknown, enter **00**. (This field is required).

FL19 (TYPE OF ADMISSION):

- Enter the type of admission code (This field is required). Please note: Type of Admission code **9** is invalid. If unknown, enter **3**.

1	Emergency
2	Urgent
3	Elective
4	Newborn

FL20 (SOURCE OF ADMISSION):

- Enter the source of admission code. If unknown, enter **9**.

1	Physician Referral
2	Clinic Referral
3	HMO Referral
4	Transfer from a hospital
5	Transfer from an SNF
6	Transfer form another health care facility
7	Emergency room
8	Court/Law enforcement
9	Unknown/Information not available

FL21 (DISCHARGE HOUR):

- Enter the hour of discharge (00-23). If unknown, enter **00**.

FL22 (DISCHARGE/STATUS CODE):

- Enter the patient status code. Whenever a recipient is discharged from the swing bed facility, a code must be entered in this block. Refer to the National Uniform Billing Data Element Specifications UB-92 manual for the appropriate discharge codes or the list below. If a recipient is still a resident in your facility at the time you submit a monthly billing, use discharge code **30**.

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04	Discharged/transferred to intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for inpatient care
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged/transferred to home care under care of Home IV provider
09	Admitted as an inpatient to this hospital
20	Expired
30	Still a patient
40	Expired at home
41	Expired in a medical facility (e.g. hospital, SNF, ICF, or free standing hospice)
42	Expired – place unknown
43	Discharged/transferred to a federal hospital

50 Hospice – home
51 Hospice – medical facility
61 Discharged/transferred within this institution to hospital-based Medicare approved swing bed
62 Discharged/transferred to another rehabilitation facility including rehabilitation distinct parts units of a hospital.
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare.
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital.

FL42 (REVENUE CODE):

- Enter appropriate revenue codes for services provided. List all *non-ancillary (Room & Board)* revenue codes in ascending **Service Date** order (**FL45**), followed by **001** for the Total Charge Line.

  North Dakota Medicaid will require use of *Revenue Code* **110-159** when billing for In-House Medicaid days and *Revenue Code* **169** for Medicare Coinsurance days. *Use of any other Revenue Codes for Swing bed claims will be invalid and will be returned for correction.*

  Please note: You **must** enter Revenue Codes for charges in Service Date order or the claim will reject. (ex. Revenue Code **169** for DOS 12/01/03 – 12/04/03 would be billed *before* Revenue Code **120** for DOS 12/05/03 – 12/31/03) on your claim.

FL43 (REVENUE DESCRIPTION):

- (Optional) Enter the revenue description.

FL44 (HCPCS/RATES):

- You **must** enter the accommodation rate for room & board or the claim will be rejected.

FL45 (SERVICE DATE):

- You **must** enter the first date of service for the specific Revenue code you are billing on that line item. If you do not enter the first date of service in this field, the claim will be rejected.

FL46 (UNITS OF SERVICE):

- Enter the units of service applicable to each revenue code billed. The total number of units for all *non-ancillary (Room & Board)* revenue codes billed on the claim should equal the statement covers period (FL 6), and should equal the covered days (FL 7).

FL47 (TOTAL CHARGES):

- Enter the total charges for each revenue code billed.

FL50 (PAYER IDENTIFICATION):

- Enter the name (left justified) identifying each payer organization in order of liability

FL51 (PROVIDER NUMBER):

- Enter your North Dakota Medicaid Provider Number (19XX) that has been assigned to you for swing bed services. Do NOT enter your hospital provider number used for inpatient or outpatient services. If the incorrect provider number is used, improper or delayed payments will result.

FL54 (PRIOR PAYMENTS):

- Enter payments from other payers, excluding Medicare, corresponding to the payers listed in FL50 A, B, and C, if applicable. Medicare payments are considered by ND Medicaid using the appropriate Revenue Code (**169**). If a recipient receives proceeds from an insurance policy that covers swing bed facility services or a supplemental policy, enter the appropriate amount(s) that apply to the total charges billed on each authorization. The amount must be subtracted from the total charges in FL 47. **DO NOT** subtract Medicare payments from FL 47. **DO NOT** enter prior North Dakota Medical Assistance payments or Recipient Liability amounts.

FL55 (ESTIMATED AMOUNT DUE):

- Enter the difference between the **Total Charges** (FL 47) and the **Prior Payments** (FL54). An entry in this block is always required. If there is not an entry in the Prior Payments (FL54), it is **required** that the total charges entered in FL47 also be entered in **Estimated Amount Due** (FL55). A claim for a Medicaid recipient must be submitted for each month the individual is in the swing bed even if the balance due is zero after insurance or Medicare payments. Other Medicaid providers cannot be paid until the swing bed claim is processed.

FL58 (INSURED'S NAME):

- Enter recipient's last name, first name, and middle initial.

FL60 (RECIPIENT IDENTIFICATION NUMBER):

- Enter the recipient's 9-digit North Dakota Medicaid ID number. **DO NOT** use the recipient's social security number.

FL67 (PRINCIPAL DIAGNOSIS CODE):

- Enter the principal diagnosis code from the ICD-9-CM (**DO NOT** enter decimal point). It is necessary to include at least one diagnosis code.

FL85 (PROVIDER REPRESENTATIVE SIGNATURE):

- This block must be dated and signed by the designated employee who has the responsibility to obligate the facility to the stipulations contained in this block. The signature may be typed, stamped, or handwritten.

FL86 (DATE BILL SUBMITTED):

- Enter the submission date in MMDDYY format.